St. Bartholomew's Hospital Journal.

VOL. IX.—No. 11.] AUGUST, 1902. [PRICE SIXPENCE.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C.*

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All communications, financial or otherwise, relative to Advertisements ONLY, should be addressed to J. H. BOOTY & SON, *Advertising Agents, 30, Holborn, E.C.*

A Cover for binding (black cloth boards with lettering and King Henry VIII Gateway in gilt) can be obtained (price 1s. post free) from MESSRS. ADLARD AND SON, *Bartholomew Close.* MESSRS. ADLARD *have arranged to do the binding, with cut and sprinkled edges, at a cost of 1s. 6d., or carriage paid 2s. 3d.—cover included.*

St. Bartholomew's Hospital Journal,

AUGUST, 1902.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

Affections of the Nasal and Air Passages in Congenital and Tertiary Syphilis.

A Clinical Lecture delivered at St. Bartholomew's Hospital.

By ANTHONY BOWLBY, C.M.G., F.R.C.S.

(*For the report of this lecture we are indebted to the* EDITOR *of the* CLINICAL JOURNAL.)

YOU will remember, gentlemen, that at my last lecture I was speaking to you about primary and secondary syphilis of the nasal and air passages in general. I want now to turn to the affections of these regions in congenital syphilis, and in tertiary syphilis.

You know that congenital syphilis differs in many ways from acquired syphilis. It manifests itself in some cases very early in life, but in other cases it is not evidenced until after the lapse of months or years. In the case of syphilis of the nasal passages the disease manifests itself more early in life than in any other place almost. You know that the common name for this condition is "the snuffles." If you were to examine the nasal membrane in a child who has what is called the snuffles, you would find there was a considerable occlusion of the nares by the accumulation of crusts, and if you remove those crusts you find, in many cases, nothing more than a general catarrhal swelling of the mucous membrane, with no ulceration or destruction of it whatever. But if you examined a little deeper you would often find in the submucous tissue that there was a gummatous deposit, and a thickening of the periosteum. In a great many cases there is nothing more than this general thickening. But in a small proportion of patients, again, upon this condition there supervenes ulceration; so that, even in infantile life, in a few months there may be caries, and sometimes even extensive necrosis. But you must remember that these conditions are rare, and that the usual manifestations are those which I mentioned at first—a seeming catarrh, a swelling of the mucous membrane, and the formation of crusts. Usually there is some thickening, but seldom more than that. Occasionally there is open ulceration and caries, and even extensive necrosis in the early months of life.

In a great many cases of congenital syphilis there is no evidence of nasal syphilis in infantile life; and even when there is evidence, a child who is treated often recovers, so that afterwards the only thing which remains to show for the disease is that the nose assumes a curious shape, the end being lumpy, tilted up, and swollen, and altogether out of proportion to the size of the nose as judged by the nasal bones and the lateral masses formed by the superior

maxillary bones. The consequence is that the nose in many children, without being extensively destroyed, or deformed, is of a characteristic shape, with a slightly depressed bridge, and rather a "blob" at its end. In other cases there is left a real impairment of growth of the bone, so that the bridge of the nose may never properly be developed at all, and the child may grow up with a sunken nose, though there has not been definite external evidence of disease as shown by destruction of bone. It does not, therefore, necessarily follow that because a child has no evident perforation of the septum of the nose and no necrosis his nose will not be ultimately of an altered shape. It may be of an altered shape though neither of these conditions has obtained. In other cases again, unfortunately, as I have mentioned to you, there are extensive caries and necrosis, and the whole shape of the nose is permanently altered, so that the patient may be said practically to have very little nose at all, as far as prominence on the face is concerned.

Later in life, when the time for infantile syphilis has passed by, there may be a condition such as I show you in this drawing. This is the face of a child of eight which presents the condition known as "syphilitic lupus," or a lupoid syphilide. You know that in describing syphilitic eruptions terms are employed which indicate more simple eruptions. For instance, we talk of a syphilitic psoriasis, which is not psoriasis at all; what is meant is merely that it is a syphilitic eruption which has the appearance of soriasis. We talk of syphilitic acne, and that again is a syphilitic eruption which bears a resemblance to acne. In the same way we talk of syphilitic lupus, which has nothing to do with lupus; it is syphilis having the appearance of lupus. This condition, which may be called syphilitic lupus, or a lupoid syphilide, or tertiary syphilitic ulceration of the nose, is a disease which may supervene at any time after the period of the second dentition. It is not very common, but it is sufficiently so to be well recognised, and therefore it is a condition which you have to differentiate from typical tubercular lupus. It differs from it chiefly in the rapidity with which it extends, and the amount of destruction of tissue which is involved, as well as in the way in which it passes far beyond the ordinary limits of lupus if it is allowed to go untreated. You will see in this next picture still further evidence of the destruction which may result from the extension of the disease. This is the face of a child of nine whose teeth present the characteristic notches which are supposed to be due to syphilis. Evidently the child had congenital syphilis. In this child's nose is seen, at a later stage, what was seen in the first picture, an extensive laceration of the skin, a wide opening of the whole of the cavities of the nose, and the destruction of a great part of the ala on the left side. That illustrates a much more extensive destruction in depth of tissue than you get with lupus until the lupus has been going on for years, and usually not then unless it has extended over a very large surface of the face. This, then, is evidence of nasal syphilis at a stage of life later than infancy. At the same time that this happens, and rarely before, there may be ulceration inside the nose, and there may be ulceration of the pharynx. The larynx, fortunately, is rarely affected in congenital syphilis, although I shall tell you presently that in tertiary syphilis it is. But the tongue is affected in congenital syphilis in a good many cases. Here is a good picture of a child, a boy aged seven, who had been under treatment one and a half years, and here you get the typical conditions of tertiary syphilis of the tongue. So you see there may be not only affections of the nose in children, but there may be affections of the pharynx with ulceration, and affections of the tongue of the same nature as those with which you are familiar in cases of acquired syphilis in the tertiary period. As far as these patients are concerned you may say in general terms that the diagnosis is tolerably simple. There is not much else that looks like an ulcerative syphilide of the nose; there is nothing which closely resembles this condition of the tongue, and therefore, without wasting too much time upon the matter, as it is a subject which one has hardly time to discuss now, it is enough to say that the diagnosis is easy, and that the treatment to be adopted is that for syphilis in general, not only by means of iodide of potassium, but also by mercury. Both of these are useful, and if administered in reasonable doses, and continued for a sufficient time, the results in these cases of syphilis of children, as apart from the cases of infancy, are thoroughly satisfactory. I need hardly remind you that the general treatment of syphilis in infants is very unsatisfactory. A large number of such patients are sure to die very young whatever you do for them. The evidence which you may detect of the disease in the nose is not the only evidence which will guide you in the diagnosis, but it will enable you to realise that probably the child has syphilitic disease going on elsewhere in its body. You will be able to see that its viscera are very likely unsound, and that, apart from the condition of its nose, it is likely to die. Moreover the trouble in the nose causes some interference with the vitality of the child, and often makes it very difficult for it to suck its food. Thus the chance of recovery of a sick child is very materially prejudiced, not so much from the amount of destruction of tissue, as on account of the difficulty which it has in taking its nourishment.

We will now leave hereditary syphilis, though there are many more things which might be said about it, and turn to tertiary syphilis. And here, again, we begin with the nose. Tertiary syphilis of the nose may attack either the external surface of the nose or the inside of that organ. Let us say a few words about the external surface first, and dismiss the subject. A person with acquired syphilis may

have such a condition of the nose as I pointed out to you as occurring in childhood,—that is to say, a so-called ulcerative syphilide or syphilitic lupus. This, then, is a condition which may occur both in congenital and in acquired syphilis, and you may expect to find patients with tertiary syphilis who have destruction of the ala of the nose, or of a considerable portion of its tip.

Next with regard to the inside of the nose. Here, of course, you have to do with conditions which are very much more serious, and this chiefly because they are so latent, and therefore liable to be overlooked. If you examine the inside of the nose in cases of tertiary syphilis, at the beginning of some syphilitic affection of the inside of the nares, you may find, either on the outer side of the nostril, on the turbinate bodies, or on the septum (the last being the more common), a swelling. No ulceration precedes this as a rule. That swelling is due to a gummatous deposit in the periosteum, and sometimes in the substance of the turbinate bodies. All that the patient complains of is some difficulty in breathing through the nose. The swelling is soft, and if the condition is on the outer side of the nose you are liable to say that it is hypertrophic rhinitis, and indeed it looks like it. But if you examine further you will find there is a much more substantial swelling; it is not the œdema which you associate with enlargement of the turbinate bodies. This swelling is different from that; it is much more thick and substantial, is often not limited to the turbinate body, and does not disappear when you put cocaine into the nose. So you have something which looks like hypertrophic rhinitis, and which may be mistaken for it. At that stage, if you recognise the disease and treat it, you can get your patient well without trouble occurring inside the nose beyond the temporary blocking and consequent difficulty in breathing. The whole of this swelling may be entirely removed by the administration of iodide of potassium and mercury, and the patient may completely recover without having a sore place inside the nose at all. You are less likely to make the mistake of not recognising this early condition when it affects the septum, because swellings of the septum are not very common apart from syphilis. They occur in tubercle, but generally the patients we are speaking of are older than patients who have tubercular swellings of the septum. Then there is new growth, but the cases are not like that. In cases of syphilitic disease of the septum there is generally a thickening and evident swelling of one side. Often, however, both sides of the septum are involved, so that you may have enlargement of the septum as a whole. If you recognise this condition you can often prevent the patient from having anything more the matter with his nose, because at this stage the condition is amenable to treatment. If you wait, or if the patient does not see you soon enough, what happens? What happens on the outer side, in the condition which resembles hypertrophic rhinitis? What happens in the septum where there is not yet any ulceration? These swellings will ultimately break down, they will ulcerate, and they will leave an open place which discharges purulent and blood-stained material, which is the débris of the tissues which have been destroyed. How much tissue has been destroyed varies immensely in different cases. In one case when the gumma bursts and discharges its contents there is found to be an ulcer, at the bottom of which the bone may not be evidently exposed, or the bone is perhaps exposed over only a very small area, and that ulcer heals up. Or it may be that there is an ulcer, at the bottom of which carious bone is extensively exposed, and this will take a long time to heal. These conditions may extend, the ulceration may progress, more bone may become carious, and ultimately the whole inside of the nose may become widely and extensively ulcerated, with perforation of the septum and necrosis of other bones. At any rate, the state of the patient after a time is that a great deal of the nose is destroyed from within. Whilst these changes are taking place, in not a few cases there is no necessary alteration in the external shape of the nose, even although there may be extensive destruction of the septum. You will be able to see patients in the throat department in whom there is a large hole in the septum of the nose, and yet the bridge has not fallen in. I want you to remember that, because it seems to be the opinion of many people that as soon as the septum of the nose is destroyed the nose falls in. But the nose does not fall in simply because of that. The nose is supported laterally by the nasal bones and the superior maxillary bones, and these do not necessarily fall in. These make the bridge. The nose does not depend merely on the support which it receives from the septum. Therefore in many of these cases you can see destruction of bone, and yet, though there is a complete breaking open of the cavities of the nose, so that they form one large cavity, there is not necessarily any material deformity. In other cases, unfortunately, there is much material deformity, and such large portions of the nose may be destroyed that either the bridge of the nose may sink in and leave the fleshy part of the nose projecting as a shapeless mass, or ulceration may extend to the tip of the nose, and all the soft parts of the organ may be destroyed. In some cases both of these conditions go together,—that is to say, a destruction of the soft parts and of the bony framework of the nose.

With regard to the differential diagnosis, when it is a case of ulceration there is as a rule very little difficulty in diagnosing the condition; but you have to keep in mind that there is a form of ulceration of the septum of the nose which is not due to syphilis; that is called "atrophic ulcer" of the septum of the nose. It occurs almost always in women, and generally in women over forty years of age. It has no definitely recognised cause. Tubercle also may perforate the nose, but that almost always occurs in quite

young subjects. Perforation of the septum of the nose by syphilis is the most common. Atrophic ulceration of the nose, let me say at once, is a very slowly extending form of ulceration, which may very likely take a year or two to perforate the septum. It occurs immediately behind the tip of the nose, and as it occurs in that place it usually perforates the cartilage and not the bone. Ultimately it gradually cicatrises at its edges, leaving, however, a permanent hole through the septum of the nose. That is a curious condition, the pathology of which we do not understand; but you may say definitely it is so unlike the course of syphilis that you are not at all likely to mistake the one for the other.

As to symptoms, I have already told you that at the beginning the only thing which the patient will complain of, before there is ulceration, is some obstruction to the passage of air through the nose. You can easily understand that afterwards, when there is ulceration, the patient complains of discharge from the nose, and it is to be noted that in many cases the discharge is characteristically blood-stained. If you find a discharge from the nose which is practically always blood-stained the case is most likely to be one of tertiary syphilitic ulceration. If, however, the patient be a child and there is a blood-stained discharge from the nose, remember that the commonest cause for that is undoubtedly the presence of a foreign body in the nose; and I need hardly say this is something altogether different from what we are considering. We are speaking about tertiary syphilis now, in which the patients are adults; and if there be a profuse blood-stained discharge from the nose, that is almost always an indication of tertiary syphilis. Other discharges from the nose are seldom regularly blood-stained. Later on the patient may complain of loss of the sense of smell, which is due to the destruction of the mucous membrane and of the terminal filaments of the olfactory nerve. Later on still the patient may have ozæna, of which, however, he will not complain so much as will his friends. Ozæna is a characteristic fœtid odour which may occur from other causes than syphilis, but it is one of the great troubles of tertiary syphilis, when ulceration has extended and destroyed much of the bone and is associated with caries or necrosis.

What you will be able to do for your patient will greatly depend upon the state in which you see him. In all these cases the ordinary antisyphilitic remedies should be employed, and always remember to employ mercury as well as iodide of potassium. I am no advocate of giving iodide of potassium and withholding the mercury. You have also to carry out measures for local cleanliness, such as the washing out of the nose with salt and water and afterwards the introduction of an antiseptic powder. In the throat department we have been using loretin and borax. The first of these is practically iodoform under another name and in another form. It has about the same proportion of iodine, which it liberates in contact with living tissues, and thus acts as a disinfectant; we use it instead of iodol, because it is cheaper and because it is insufflated much more easily. After having used other preparations we have come to the conclusion that on the whole loretin is better than most things. I always use it with borax, because borax liquefies mucus and promotes a more watery discharge from the nose, and seems to prevent to some extent the formation of the thick crusts and scabs. I am not particular as to the exact form of antiseptic which you may use; the essential thing is that you should wash the nose out to get rid of the crusts and scabs, and afterwards that the patient should use some antiseptic powder to blow into the nose. Most of these cases yield to treatment, but a few of them do not.

And now let me point out one of the results of syphilitic ulceration of the nose when the ulceration has ceased. Cicatrisation ensues. In the case which is illustrated in the picture I show you cicatrisation has ensued to an extent which is very rare; nearly the whole of the nares is completely occluded. There is an absolute stoppage of the nostrils by scar tissue, so that the patient has no breathing-room at all. This is a complication which you have to bear in mind, but it does not often happen. When there is complete occlusion of the nares as a result of ulceration of a syphilitic nature the cases are most difficult to treat. The treatment, indeed, is almost sufficient to occupy a lecture by itself. It is very difficult to restore a passage or channel in any part of the body which has been closed by a cicatrix, and you have, in such patients, to perform some plastic operation.

Let us now pass to the other end of the nasal passages, namely, the pharynx. There is not so much to be said about the pharynx as about the nose in tertiary syphilis; but the back of the pharynx may be ulcerated, and so may the roof of the mouth and the soft palate. Let me remind you that the roof of the mouth is the floor of the nose; what is the ceiling of one story is the floor of another. The result is that ulcerations inside the nose may result in perforation of the palate; and you may feel, before there is perforation, the same swelling which I have mentioned as occurring inside the nose before ulceration commences there.

If you are examining a patient with syphilis, and if you find, after having satisfied yourself of the evidence of syphilis inside the nose, that there is a bulging on the upper part of the hard palate, you may be sure that if you do not get that patient quickly under the influence of treatment there will be perforation inside the mouth. At a later stage the palate may be ulcerated, and so may the pillars of the fauces and the pharynx. These ulcerations you may see either at the time that they are recent and open, or you may see them later, when the process of cicatrisation is going on. The picture which I have shown

you of occlusion of the anterior nares represents the similar condition which may occur after ulceration in the pharynx. A little time back a patient came here quite unable to breathe through the nose. The examination of the anterior nares showed nothing, but on opening the mouth you could see that the palate was drawn upwards, and was adherent to the pharynx, that the pillars of the fauces were dragged upon, and that there was only a small hole left through which one could pass a fine catheter into the naso-pharynx. The whole of the rest of this space was shut off by an extensive scar, the result of tertiary syphilitic ulceration of this region, which had destroyed the uvula and the pillars of the fauces.

And now, in conclusion, a few words about tertiary syphilitic ulceration a little lower down, namely, in the larynx.

With regard to the larynx there is not so much to be said, but what is to be said is of very great importance. In many cases a patient who has tertiary syphilis has a hoarse, harsh voice. If you examine him you will find either swelling or ulceration to account for it. The swelling may be an ordinary gummatous swelling, entirely analogous to that which I described as taking place in the septum of the nose or the turbinate bones; and you may find on one side of the larynx a lump which, we will say, is above the vocal cord, for the ventricular band is a very common place for this condition, and so is the ary-epiglottic fold. As that swelling increases it infiltrates the muscles, and although the cord itself is free and may appear normal the movements of the cord may be hampered, and the patient as a result talks with difficulty. If you see the same patient later on you may notice that the swelling has disappeared and an ulcer has come in its place—the gumma has broken down. Here, in exactly the same way as in the nose, there may be superficial ulceration or deep destruction of the muscles in the larynx, of the ligaments, or of the crico-arytænoid joint; and as a consequence there may be a permanent alteration in the movements of the cord owing to the destruction of the muscles, and to the formation of fibrous tissue, and perhaps to ankylosis of the crico-arytænoid joint. Then, in exactly the same way as gummatous infiltration in the nose extends to the periosteum, so it may extend to the perichondrium and the cartilages of the larynx, although fortunately this is more rare. It may then give rise to perichondritis, with effusion underneath the perichondrium, entirely analogous to periostitis, so that sometimes one side of the larynx may be blocked by a large swelling which completely occludes that side of the larynx, and quite hides all the normal tissues. All that you can see in such a case is a large deep-seated swelling lifting up everything, and making the whole of the anatomy of the larynx so completely altered that you can hardly recognise it.

Let us now go a step further. Ulceration may result in destruction of cartilage. We have got as far as perichondritis, and the ulceration may go on to ulceration of the cartilage. Of all cartilages which are likely to be destroyed the chief is the epiglottis, which is destroyed more often than is any other in cases of tertiary syphilis. Here is a picture which shows very wide-spread infiltration and ulceration inside the larynx; and here is another, from a man who was forty years of age, in whom there has been very extensive destruction and ulceration of the essential parts of the larynx, including some parts of the vocal cords. I have already said that hoarseness is the characteristic condition early in these cases; and the other thing to be noticed is that this condition of ulceration and swelling in the larynx in syphilis is almost painless. It thus differs materially from many, though not from all cases of tubercle, for many cases of tubercular laryngitis are very painful. Syphilitic laryngitis hardly ever causes pain, even if it is very advanced. Later on, not only may the voice be materially altered as the parts are infiltrated, the muscles destroyed, and the edges of the cord ulcerated, but on account of the amount of swelling there is sometimes considerable dyspnœa, and if treatment is not applied sufficiently quickly you may have to do a tracheotomy. You may find that a patient who has not had dyspnœa will on a certain day, within a few hours of your seeing him, develop severe dyspnœa. The explanation is that in a case where there has been already an open ulcer of the larynx the patient may, by exposure to cold or wet, have an ordinary catarrh; and where there is already much swelling of the larynx, the swelling which supervenes from the catarrh is sufficient to turn the balance and make it difficult for him to get a sufficient quantity of air down into the lungs at all. Later on, as ulceration ceases and cicatrisation ensues, the larynx may be contracted in the process, and so there may be stenosis. The result may be that after the ulceration has ceased the dyspnœa may be much worse than it was during the active process of ulceration. It will be serious in proportion to the amount of tissue which has been destroyed and to the fixity of the parts which are left; so there is no hard and fast rule about these cases. Fortunately a large majority of the patients who have syphilitic ulceration of the larynx recover without any permanent dyspnœa, though with altered voice and permanent hoarseness, conditions due to the damage which has been done to the vocal cords, and to their fixity, which is irrecoverable. But most of them have not any permanent dyspnœa, though some of them may have some shortness of breath on exertion now and again. You may, however, meet with cicatrisation, analogous to that which I showed you in the case of the nose, which may result in a gradual drawing-in of the orifice of the glottis, so that dyspnœa may be serious, and this dyspnœa you may have to treat by the use of a permanent tracheotomy tube. The dyspnœa which is the result of the swelling occurring whilst the syphilitic pro-

cesses are in progress you may have to treat by the employment of tracheotomy, but in the majority of such cases, where the dyspnœa is due to the inflammatory swelling, the use of a tube will only be temporary.

You will see, then, that in general terms syphilis, as it affects the nose, or the pharynx, or the larynx, begins in a large number of cases when it is in the tertiary period in a swelling. If you recognise it when there is only swelling, you have recognised it in time to prevent very much damage in a large number of cases. In the second stage this swelling is succeeded by ulceration, with destruction of tissue to a very varying extent. Thirdly, there ensues cicatrisation, and that may result either in the natural healing of the ulcerated parts, leaving no other damage, or it may result in stenosis, so that there may be narrowing of the nares, or even occlusion and stenosis of the larynx, causing more or less serious dyspnœa.

Notes of a Holiday in and Impressions of Spain.

By HENRY RUNDLE, F.R.C.S.

MOST people who travel at all have visited France, Belgium, and Switzerland, but Spain is a little off the usual track of European travel, and it attracts relatively a mere sprinkling of English visitors. This is due to many causes. It is less convenient of access than these countries. The train service is bad; one fast train only per day, and that usually run at night, is not enticing as a means of locomotion. These fast trains seem to stop at all the stations, and the ordinary trains stop between the stations as well. The hotels are not up to date; the culinary art, to put it mildly, is unsatisfactory in all but the larger towns, and many of the comforts which an Englishman is accustomed to are absent. Whatever drawbacks there may be, Spain is a fascinating country, and deserves a foremost place for holiday travel, being rich both in historical associations and romance, and also in treasures of art and architecture. I hope that these reminiscences of a recent holiday spent there will be interesting, especially to those who intend to be present at the International Congress of Medicine to be held in Madrid in April, 1903.

Cheerless and discouraging were the circumstances under which we started upon our journey southwards on February 1st, 1902. The Channel crossing was abominable. A gale which surpassed anything experienced for ten years at least made it highly dangerous to attempt to enter the harbour of Calais. The steamer therefore went on to the sister port of Boulogne, which has the advantage of being sheltered by Cape Grisnez, and there we landed. Most of the passengers looked the very incarnation of sea-sickness. We reached Paris shortly before midnight, and a very good dinner quickly soothed our squeamish stomachs.

The next day we started from the Gare d'Orsay. This station is one of the finest, and certainly the cleanest and quietest for its size and importance, in Europe. There is no smoke. The train is drawn by an electric engine for some little distance out of Paris, and by a similar engine both passengers and luggage are lowered to the station.

Leaving at 12.15, we travelled across France through the valley of the Loire, a lovely country studded with old châteaux, reminding one of "the Dukeries" in our own country, and passing Tours, Poictiers, Bordeaux, and Biarritz to Irun, the frontier town, where the luggage was examined, and we and our luggage were transferred into a Spanish train. Here we first met with the Guardia Civil, a noteworthy feature of Spanish travel. The Civil Guard is a fine corps of nearly 20,000 men. It is the most trustworthy body in Spain for the defence of law and order, and is under the control of the War Minister. Two men belonging to this corps travel in every train. In case of any difficulty it is best to apply to them for help.

About half an hour after leaving the frontier we passed through San Sebastian, the summer resort of the Court, and then entered the gorges of the Pyrenees, with magnificent mountain scenery of the wildest kind. After traversing barren and treeless plains we reached Burgos. It was piercingly cold here; the streets were covered deep in snow. On arriving at the hotel we were glad to warm ourselves over the glowing embers of a brazero, for there were no fireplaces in our rooms.

Burgos is the home of the Cid, the national hero of Spain. He was born and spent a part of his life here, and is buried in a convent a few miles from the town. The cathedral is the finest Gothic church in Spain after those of Seville and Toledo. The Chapel of the Constable, with its richly carved tombs of the family of that name, is very fine. Close to the west end of the cathedral is San Nicholas, a church well worth seeing for its beautiful high altar, carved in stone from floor to roof. We drove to the Carthusian convent of Miraflores. A monk who took us round asked if we were Americans, and seemed relieved on being told that we were English. Evidently Cuba and the events of 1898 were still in his thoughts. We also went to the nunnery of las Huelgas, a refuge for women of noble families condemned to a life of seclusion, and to the Hospital del Rey. This building, founded in 1225 and restored in 1862, is ill-adapted for a hospital. The beds are placed in small alcoves projecting from a long cheerless corridor, with small windows at the top.

It was a night's journey from Burgos to the Escorial, a great stone building telling of greatness and death, and comprising in itself a convent, a church, a palace, and the Royal Mausoleum of Spain. This is built in a barren waste

with a range of hills behind, reminding one of Dartmoor. It is one of the gloomiest places conceivable. Gautier, in his *Voyage en Espagne*, suggests that a man, after seeing it, can always console himself, whatever the trouble of his life may be, by thinking that he might be at the Escorial, and is not. Philip II ordered the Escorial to be built as his own tomb, and had it planned in the form of a gridiron, in honour of St. Lawrence, because he had invoked his aid during the battle of St. Quentin, and was successful in routing the army of France. The church is magnificent, and ranks as one of the great Renaissance churches of Europe. Beneath the high altar is a chamber reserved for the burial of kings and the mothers of kings, and connected by a passage is the burial-place of the rest of the royal family. The most interesting room in the palace is the little inner room or cell in which Philip II died, from which, through an opening into the chapel, he could see the celebration of mass while too ill to leave his bed.

In the afternoon we left for Madrid, a distance of eighteen miles. Our first impressions of the capital were not promising, for the weather was raw, wet, and disagreeable. The surroundings of the city are not attractive. It was made a royal residence by Charles V in 1524, on account of its bracing air (it is 2130 feet above the sea), which he thought would keep him free from gout. We found it very cold. Let those with weak lungs avoid Madrid in the winter. The men wrapped themselves up in long cloaks drawn quite over their mouths. There is a Spanish saying that "the wind in Madrid cannot blow out a candle, but it is quite enough to kill a man." We were told that in summer it is very hot. These extremes of temperature, among other causes, give Madrid the unenviable distinction of being the most unhealthy capital in Europe. In 1901 the deaths numbered 17,242, and of these 4064 were of children under four years old. This gives a rate of about 33 per 1000. Two great evils in Madrid are food adulteration, which is virtually unchecked, and overcrowding. The 528,000 inhabitants are herded in 17,000 houses, which gives an average of 31 persons per house.

There are many small hospitals in Madrid, and four large ones, viz. the General Hospital, San Carlo, San Juan de Dios, and de la Princesa. We visited the last, which is the most modern. It was built in 1852 by Queen Isabel II to commemorate the birth of the Princess of the Asturias, and was restored and enlarged by King Alfonso XII in 1880. It contains sixteen wards, with sixteen beds in each, and is built in three stories around a central space. The top story is for the accommodation of nurses and staff. The floors are of marble, and there is a dado of tiles on the walls; but the sanitary arrangements are defective, the lavatories, etc., being placed immediately inside the entrance to the wards. This was the best hospital we saw in Spain, and surgery seemed to be in a much more advanced state here than elsewhere in the Peninsula.

Madrid is less distinctly Spanish than any other city we visited, and has much the same appearance as other European capitals. The Puerta del Sol, the largest *plaza* and the favourite lounge in the city, and the Prado, or Rotten Row, have a gay and lively aspect. In the latter there was a show of carriages and horses as good as man could desire. But the two chief sights are the Royal Armoury, which contains the most perfect collection of mediæval armour in the world, and the Picture Gallery, which is worth a journey to Madrid to see. Velasquez, the unrivalled portrait painter, can be seen here as in no other gallery. He displayed his great genius in painting the plain-looking Infantas in the ridiculous costume of the period, with their curious surroundings of dwarfs and ferocious-looking dogs. They seem as if they were about to walk out of their frames. We could, with little difficulty, believe the story that a couple of these pictures, placed upon easels in Velasquez's studio, made onlookers fancy that the real persons were actually there. In this gallery are many of the most lovely works of Murillo, the painter of holy people and angels and beautiful children. Here is his famous picture "El Tiñoso," or St. Elizabeth of Hungary tending the sick poor, in which he expresses at once both the active human and the devoutly religious conception of life. We knew but little of Goya until we saw his pictures here. He was the painter of peasants and the barbarisms of the bull-fight, where he was evidently at home. The gallery of modern art in the Calle de Alcala contains pictures of great interest. Madrid has but few fine buildings: the most important is the royal palace on the west side of the city. There is no cathedral, and only one fine church, San Francisco. It has the form of a large rotunda with six chapels, which are adorned with many good frescoes and pictures by modern Spanish artists. It was the Church of the Franciscan Monastery before it was turned into a parish church, and the monastery is now used as a barrack and military prison.

From Madrid we went to Seville, a journey of fourteen hours. In one of the most delightful papers of that most delightful book, *Virginibus Puerisque*, Stevenson has charmingly described the sensations of a man "ordered south," as he passes from frost and cold into sunshine and warmth. This was our experience. Hitherto we had been in winter, but in Seville the sky was clear, and the air warm and sunny like that of early summer. We were among the palms and orange trees bearing fruit, and geraniums, roses, and carnations flowering in abundance. We went at once to the cathedral, which ranks in size only after St. Peter's at Rome. It is very grand, and the pictures are magnificent. Among the finest are "The Guardian Angel" and the celebrated "St. Antony of Padua," both by Murillo. The figure of St. Antony was cut out and stolen in 1874. A big reward was offered for its recovery, with the result that it was found in America and brought back again in the

following year. We were in Seville at Carnival time, and had an opportunity of seeing a curious and an unique ritual, a dance by ten of the choir boys before the altar. They were dressed like pages in doublets of blue satin and gold, and white knee-breeches. Their graceful and dignified movements to the accompaniment of instrumental music and castanets were very striking and most reverent.

Standing high over the cathedral is the famous Giralda tower. It is the work of the Moors, and was designed by Al Geber, the Arabian, with whose productions, of another kind, schoolboys have painful acquaintance, for he is supposed to have been the inventor of algebra. We had no opportunity of seeing a bull-fight. One of our party went to a cock-fight, which seems to have been a cruel and brutal excuse for betting. There is much truth in the couplet,

> "He who hath not Seville seen
> Hath not seen strange things, I ween."

Seville is not merely a place of pleasure. Merchant ships of large draught were lying in the Gua'alquiver close to the city. The tobacco factory, employing 5000 women workers, is an immense building. In spite of dirt and evil smells it should be seen: so also should the pottery where Moorish lustred ware is made.

On leaving Seville we travelled *viâ* Ronda to Algeciras, a Spanish town opposite Gibraltar, where the railway ends. There is an excellent hotel here, the "Reina Cristina," under English management. Here we stayed the night, and early the next morning crossed the bay to Gibraltar, a passage of half an hour. At the gate at the end of the quay the sentry interrogated us as to our nationality: we passed on, proud to find ourselves upon British territory. We spent two days on the Rock, a place dear to every Englishman as a record of past valour. Having obtained the necessary permit, we visited the long, cool, rock-hewn galleries, from the portals in which we had lovely glimpses of the sea, and Spanish hill-tops, and the coast of Africa, which is fourteen miles away. This great limestone rock, sitting so square and seemingly solid on the sea, is honeycombed with these spaces. It is the especial character of the rock material that it will stand, when hollowed out, without any support. The new docks, three in number, constructed at a cost of £5,000,000, are nearly finished. The long principal street was a lively sight, with a motley crowd of many nationalities. So, too, was the market for meat and vegetables, with stalls held by Spaniards on one side, and by Moors on the other. We were disappointed in not catching sight of any of the Barbary apes, the only wild monkeys to be seen in Europe.

On our way back we stayed a night at Ronda, which is grandly situated, and was familiar to us from the excellent description in E. W. Mason's novel *Miranda of the Balcony*. From Ronda to Bobadilla is a run of a little over an hour. This is an important junction. We lunched there and changed carriages for Granada. The railway ride is very pretty, and passes through the estate of Soto de Roma, which was given by the Spanish Government to the Duke of Wellington. We stayed at the Washington Irving Hotel, which is close to the Alhambra, the most famous show place in Spain. It is always open to the public, and a guide who only repeats what one reads in guide-books is quite unnecessary. The exterior of the Alhambra is bare and plain, but there is nothing more lovely in Moorish art than the interior, with its spacious courts and fretted ceilings, and filagree walls covered with a tracery as delicate as frost-work. Near the Alhambra is the Generalife, the summer palace of the Moorish kings. It is not so large or magnificent as the Alhambra, but the palace gardens, with old cypresses and oranges and myrtles, are still as they existed in the days of the Moorish kings 600 years ago.

Up the hill above the hotel a glorious view is to be had. There are times when nature appeals to us more strongly than does cathedral, palace, or picture. Such an instance was a sunset which we saw from this point. The bold ragged spurs of the Sierra Nevada, covered with snow, stood out grandly against the sky. In the foreground was a lovely landscape, with woods and dwellings set far apart. As the sun sank into a bed of cloud, and then behind the peaks, a faint golden light crept over the snow-clad mountains, producing on those who had eyes to see a mental impression which will always be remembered. It was a Sunday evening, no sound was to be heard, a deep calm pervaded the land on which we stood wrapt in admiration.

The cathedral, which is in the town, is well worth a visit. It contains the magnificent tombs of Ferdinand and his wife Isabella, the great queen who sent Columbus to find the New World. We drove to the Gipsy quarter, a straggling village composed of holes cut out in the side of a hill. These gipsies are not wanderers as in England; they have settled in some of the most prosperous cities of Spain, and make a living by stealing, telling fortunes, and dancing.

Although the distance from Seville to Cordova is only seventy-five miles, the journey took nearly eight hours, owing to changes and waiting. This town, which during the government of the Moors was the capital, and had a million inhabitants, is now poor and half deserted. Its great treasure is the vast and wonderful mosque: the outside has a heavy appearance, but the interior is a most beautiful example of Moorish architecture. The low roof is supported by a forest of columns, nearly a thousand in number, surmounted by horseshoe arches, on which are exquisite carvings. Some of the columns in the centre have been removed, and a Christian church erected. The most interesting part of the building is a small chapel, the Mihrab, where the Koran used to be kept. It is roofed like a shell with a block of white marble, and decorated

with mosaics of glass and gold. On the spot where the Koran rested the marble floor is worn into a circular hollow by the faithful Mussulmen, who used to approach it crawling on their hands and knees.

Leaving Cordova at 10 p.m., a long and tiring journey through the night brought us to Toledo the next morning at 11.30. Seen from a distance the appearance of this city, which was once the capital of the whole of Spain, is most imposing. It is surrounded on three sides by the Tagus, and like Rome it stands on seven hills. The cathedral is very grand, and is the See of the Archbishop of Spain. Street says that this cathedral "equals if it does not surpass all other churches in Christendom in the beauty and scale of its plan." The carving of the stalls and the stained glass in the windows are superb. On the walls of the church of St. John of the Kings are hung heavy chains, removed from the limbs of Christian prisoners, who were released when the Moors were expelled. Close by are lovely Gothic cloisters, which have been recently restored. Sword-blades, daggers, and knives, for which Toledo has long been famous, are still made there, as perfect as ever. The old Toledo blades were so elastic that they could be rolled up like a watch-spring. Formerly the Jews were very numerous and important in Toledo: two old synagogues which contain fine Moorish work still remain.

In the evening we went on to Madrid, and found the people in a state of consternation on account of riots that were taking place in Barcelona. We had arranged to go there, but when it was announced that men were being shot in the streets, and that the disturbances were so serious as to warrant the reserves being called out and martial law proclaimed, we changed our plans and went to Biarritz, a delightful place for a rest after three weeks' hard work sightseeing; then to Bordeaux, a prosperous commercial city with as fine a water front as any city in Europe, thence Paris, and finally home.

Looking back upon this visit one fact stands out distinctly, viz. that Spain is in a lamentably backward state. Two amusing incidents were recorded lately in a Spanish newspaper, which could only have happened in such an unprogressive country. The students of Madrid and other universities held meetings, and agreed to present a petition to the authorities that, in honour of the King's coming of age, they should be given their degrees without the formality of a previous examination. The students were not unanimous in this modest demand. Some of them expressed a preference for examination, but the "slack" ones carried the day. In the same paper is an account of a disturbance in the women's ward at the Hospital of San Juan de Dios, occasioned by the punishment of three patients who refused to say their prayers. It is stated that the ringleaders were sent to prison for a fortnight, but that after undergoing this penance they would be allowed to return to the hospital to complete their cure.

It is strange that Spain was more prosperous under the Moors than she has been under Christian rulers, and that since the Moors were driven out, the nation has almost continuously retrograded. Some four years ago the most prominent English statesman, in a speech delivered at about the time of the destruction of the Spanish fleet in the Pacific, spoke of Spain as a "dying" nation. It is certainly hard to realise that this shrunken Power was England's predecessor as mistress of the seas. Still Spain is far from being a worn-out country. There is no land in many respects more highly favoured: she has mineral wealth, a rich soil with an immense variety of products, grand harbours and broad navigable rivers, and is capable of great development.

During the past seventeen years the position of the Queen Regent has been a difficult one. Summed up in the fewest words, it may be said that under her rule there have been peace, political consolidation, and material development at home; while abroad the loss of the last vestige of Spain's once splendid colonial empire, and with it much of its national pride, may be a blessing in disguise. The country has been relieved from a great drain upon its money and its men, and the hands of its rulers are more free to cope with works of reform at home.

Alfonso XIII, born a king six months after his father's death, succeeded to supreme power on his sixteenth birthday, May 17th, 1902. The task before him of combating the growing forces of republicanism and socialism is not an easy one.

Smithfield Letters.—II.

Collected by JOHN STREET ROAD.

DEAR BOY,—It is now many posts since you received any letter from me. My health, though not fundamentally bad, yet, for want of proper attention of late, called for some repairs. I shall drink water for a month and avoid the comforts of social life. I have been much troubled of late by a dropsy in my feet, and I want you to be my oracle now that you are so far advanced in your studies. It has occurred to me that there is in your hospital a physician who has some skill in this disorder, though his name I am not at this time able to recall. My memory, which, as you will have observed from my letters to you, is in many respects marvellous, can never provide me with anything but quotations; hence I must appeal to you to act in its stead.

Your last letter gave me a very satisfactory account of your manner of employing your time at Mackenzie's; but I am not willing that you should go on your journeyings through the lower quarters of the city without a *valet*, and one that speaks Yiddish will be best fitted for the work you

have in hand. And while you occupy your days in acquiring that technical dexterity without which success can never be yours (here I must remind you of that quotation, "*Ubi dolor ibi digitus*," which is the motto of the famous ointment H—m—c—a, for my quotations will out!), yet you should by no means neglect to occupy your evenings with the pleasures of the town. There is hardly any place or any company where you may not gain knowledge if you please.

Whatever I myself see or hear, my first consideration is whether it can in any way be useful to you. As a proof of this, I went accidentally into a print shop the other day, where, among many others, I found one print from a famous Italian picture, *Il Studio del Physico*, or *The School of Medicine*. An old man, supposed to be a professor, points to his scholars, who are variously employed in medicine, surgery, and the art of midwifery. With regard to medicine he wrote, "*Tanto che basti*," that is, *as much as is sufficient;* with regard to surgery, "*Tanto che basti*" again; and with regard to the study of midwifery there is written, "*Non mai a bastanza*"—*there can never be enough.* I understood this to mean that you may cultivate enough medicine and surgery to enable you to pass your examinations, but it is the third branch which will make your practice a lucrative one. Yet, as I examined the picture more closely, I found depicted in the clouds at the top of the piece three midwives (approved by Act of Parliament), with just this sentence written over them: "*Senza di noi ogni fatica é vana*," and I cannot find a meaning to this, for even my memory fails me at this line, which is not included in my *Dictionary of Quotations*. I would be obliged if you could obtain for me a rendering of the words from one of your tutors.

At one of your dinners I remember to have heard Dr. C— express himself fluently in foreign tongues; it may chance that even this is no stranger to him.

Since I last wrote to you I am informed that a famous building in your neighbourhood is being pulled down; I refer of course to the Newgate prison; and I must confess I cannot conceive where you and your fellows will now spend your leisure time, but I pray you inform me whether there is not perhaps some more recent asylum set apart for the disciples of Æsculapius; the votaries of Bacchus I am told are appropriately housed in Vine Street in their hour of need.

Now I must not conclude without asking you whether you suppose this to be the first time a housebreaker has been in the Newgate gaol? my memory is again treacherous on the point. I shall be content with an answer in three weeks or so: the friend who propounded the question to me is, I hear, not likely to recover. Adieu.

Bart.'s in Calcutta.

(*From our own* CORRESPONDENT.)

IN the "long ago," when, at the Annual Footer Dinner, one used to join in the vociferous applause which invariably greeted the toast of "The Old Bart.'s Men," and when one heard the "Old Bart.'s Man" who replied enlarge—as he always did, whoever he was—on the toughness of the "link that joined Old Bart.'s Man to Old Bart.'s Man in the most distant parts of the world," one used to accept it all as a part of the Bartholomean creed. Yet few of us were prepared to find how true it all is.

There is in India a small multitude of Bart.'s men, and one meets them in the most out-of-the-way and unexpected places, and everywhere the traditions of the Old School are maintained with the greatest loyalty. In my own experience I can recall a number of occasions when my newness to the country and juniority in the Service was tempered by my good fortune in meeting an Old Bart.'s Man, until then an absolute stranger, who, as soon as he found I was from Old Bart.'s, took me up and gave me every possible help and assistance, often at considerable inconvenience to himself. Sometimes it took the form of supplying some article of camp kit that inexperience had forgotten to provide; at others it was a kindly coaching up in the intricacies of the Service, and the best way to set about getting what one wanted; and in every case it was a friend in a strange country, and a friend who talked affectionately of "the square," and spoke of the staff by their Christian names.

Calcutta at present has a good share of Bart.'s men—the "Bart.'s ring" it has been called by others!—some of whom have done many years there; and nowhere is there a group of Old Bart.'s Men who take a greater pride in or speak more affectionately of the old place.

A few weeks ago at a farewell dinner given to O'Kinealy and his wife—who are going home on leave—by Bird, there were among the company no less than five Bart.'s men: C. P. Lukis, Physician to the Medical College and Lecturer on Materia Medica; F. O'Kinealy, Civil Surgeon of Howrah; R. Bird, Civil Surgeon of the 24 Pergunnahs; B. C. Oldham, 1st Resident Surgeon; and H. Meakin, 2nd Resident Surgeon at the Presidency General Hospital.

Many were the reminiscences of Bart.'s, and even a rattling fire of story after story failed to exhaust the supply, though carried on to a late hour. Old friends in the shape of Bart.'s stories, that had slipped into the byways of one's memory, were dragged out, and they in turn dragged out others. Sometimes it was a mimicry of a mannerism of some revered member of the staff that brought a howl of laughter, sometimes an incident at consultations or in the out-patient room or surgery, or a story of the "rooms" or Lecture Theatre. Often it was a reference to some con-

temporary,—and I should like to be able to say how *many* names were mentioned!—but it always began with "Do you remember?" And what *didn't* we remember, sitting under the punkahs in Bird's verandah?

Since then Oldham has gone to Patna as civil surgeon, and H. T. Walton has come in his place as first resident surgeon to the Presidency General Hospital, while F. P. Maynard has come in as Professor of Ophthalmic Surgery at the Medical College. F. V. O. Beit passed through a short time ago on his way to Burmah, and there are several other Bart.'s men near enough to come in occasionally.

So the old place is well represented here, and we hope to get in a goodly number for the Old Bart.'s Dinner, which has now become an annual institution during the cold weather in Calcutta.

The Noble Art of Skrimshanking.

By G. E. CATHCART, M.R.C.S., L.R.C.P.

I SHOULD be very sorry if this heading were to give anyone the false impression that skrimshanking is, or has ever been, in any way a common vice in the army of occupation. It is not likely to do so. Yet amongst an army of 200,000 odd, recruited "from all the ends of the earth," some black sheep are unavoidable; nor can you count these same sheep so very black, making due allowance for *badly* "fed-up" men, over a year perhaps on a blockhouse line, or after two years' *almost* continuous trekking.

It is with one of the more adroit of these gentlemen and his "ailment" that I shall now attempt to deal.

The sleeping sickness.—This I take to be a rare disease (in no way to be confounded with its namesake of the Upper Congo, or true African lethargy). Its pathology is quite unknown, and the signs and symptoms vary widely with the tastes and histrionic abilities of the patient. My only case was as follows:—I was then on blockhouse duty on a line manned by His Majesty's —th Regiment of Foot. A blockhouse about two miles off telephoned up that one of their men was seriously ill. I arrived. One's arrival lacks dignity, as to enter a blockhouse necessitates, first, a stroll through the mazes of a barbed-wire entanglement, which catches one portion after another of the outlying regions of one's anatomy, eliciting wild and wicked words, together with fragments of one's riding breeches. Then follows a crawl after the manner of the beasts that perish through a species of square tunnel 3 ft. by 3. During this stage of arrival one is apt to be forcibly reminded of one's "latter end"—an excellent moral tonic according to moralists—by striking it sharply against the top and outer edge of the tunnel, and "jamming" ignominiously.

I found the patient in the dorsal decubitus. He complained of "pains all over" and inability to eat. His temperature was slightly raised, 99·8° F. if my memory serves, but his tongue was clean; the rest of the physical examination revealed nothing, classing him conveniently as "not yet diagnosed" (the N.Y.D. of the R.A.M.C.). My treatment was purgative and antipyretic, and leaving him a tin of milk, and striking him off duty, I departed as rapidly as the above-mentioned fortifications would allow.

I had that afternoon to take over a small Field Hospital about nine miles away, during the absence of the medical officer in charge.

I was relieved about midday of the following day and returned to my camp, only to hear that the worthy I had visited on the previous day was vastly and horribly worse, could not speak, and had been quite unable to take nourishment of any kind, which, put more boldly, meant I suppose that he did not fancy tinned milk (I don't myself).

Greatly worried, I telephoned to the Field Hospital for a tonga, and saw my unfortunate patient again.

At this point of my tale I regret its original title, wishing I had substituted one more worthy, such as "The conscious simulation of morbid conditions carried to the level of one of the Fine Arts." "Sed litera scripta manet." He was still recumbent, and I did not like his looks at all. His eyes were half closed and dull, and he was somewhat cold as to the hands and feet. His brow was clammy; also at the mention of brandy he gave no sign. His teeth chattered idly against the glass, and I had to drench him as a pony is drenched. He spoke no word, but moaned feebly. Yet (strange and conflicting fact!) his pulse was hardly in accordance with the above-mentioned signs. It was a full pulse, somewhat rapid, and regular as an eight-day clock. His temperature was now 98°. Making him as comfortable as a tonga will permit, and making a note (unfortunately a mental one) that, though the poor gentleman was doubtless ill, he was hardly as near death as he would have me believe, I sent him up to the Field Hospital.

(In relating this I am fully aware that, following the example of many of my seniors and betters, I am "giving myself away upon paper.")

The further details of his case unfortunately only reached me later, indirectly. I would have given much to see them. On his arrival at the Field Hospital the medical officer in charge was puzzled as I had been, but taking his pluck into both hands he made a diagnosis of "auto-intoxication," and sent him on to No. 3 General Hospital, Kroonstad.

The orderly medical officer there, seeing a man apparently on the verge of dissolution, sent at once for the officer in charge of the ward (a grizzled R.A.M.C. major), who summed up the case rapidly, and called for a long pin. At the second application of this "specific" the

patient languidly opened his eyes; at the third he sat up in bed suddenly, and informed the major with surprising vigour who he considered his (the major's) mother to have been, adding a corollary to the effect that he (the major) was "an ensanguined person of no social importance." He said other things too, which cannot be set down here ——. His further progress to recovery was rapid and uninterrupted.

A case like this makes people tired, and saps the milk of human kindness. *Experientia docet!*

A Case of Cirrhosis of the Liver with Symptoms resembling Uræmia; Recovery for over a Year.

By JOSEPH A. ARKWRIGHT, M.D.Cantab.

IN the May number of this JOURNAL a Clinical Lecture by Dr. Gee was published, in which a case of "Hepatic Uræmia" was described. The following case is, I think, of the same nature.

The patient (S. W—) was a publican and farmer, a tall, heavy, stout man, 50 years of age, who for some years had had an enlarged liver. He was in the habit of drinking a considerable and indefinite amount of beer and spirits, but not of getting drunk. He led a fairly active and industrious life. He told me that his brother also had an enlarged liver.

During the latter half of March, 1899, he complained of being drowsy and feeling tired, but he did not sleep soundly at night, in spite of occasional doses of bromidia. He frequently felt heavy and unable to work; his skin and conjunctivæ were slightly jaundiced, the face of a dark purplish-brown colour due to jaundice in addition to the purplish capillary congestion.

At the beginning of April he was suffering from dyspnœa, œdema of the legs, tremor of the hands, and severe pains in the arms and legs, but he did not stay in bed. The edge of the liver was hard, and was felt at the level of the umbilicus; the bowels were open, two or three loose motions being passed daily. The urine was scanty, dark-coloured, and a thick cloud of albumen appeared on boiling and adding dilute acetic acid.

The diet for the last two or three weeks had consisted almost entirely of milk food, but he also took some spirits, though less than usual.

On April 6th he was worse, and had been unable to get out of bed. Attacks of stupor, from which he could not be thoroughly roused, had occurred frequently during the last few days, and on this day the lethargy and stupor were continuous but variable, and were sometimes so great that he could scarcely be roused to speak: any movement required a great effort. The pulse was 100, full and strong; the apex-beat of the heart was felt in the fifth space, just outside the nipple line.

Dyspnœa was constant but variable in degree; sometimes it became worse, suddenly causing him to sit up in bed. Muscular twitching, jerkings of the limbs, and hiccough were frequent. The knee-jerks were very sluggish, and could scarcely be obtained at all.

The patient appeared to be gradually becoming unconscious, and sinking into a coma resembling that of uræmia.

On the evening of April 6th, in spite of the apparently free action of the bowels, a drachm of sulphate of magnesium and half a drachm of carbonate of magnesium were given, and repeated every two hours, and a sixth of a grain of nitrate of pilocarpine was given hypodermically. Alcohol was completely withheld.

On April 7th the patient's condition had improved; the bowels had been open six or seven times, large watery motions having been passed. He had slept for four or five hours; this was the first real sound sleep which he had had for a month.

On April 8th he had less pain in the limbs; there was general improvement, the knee-jerks were active; the sulphate and carbonate of magnesium were continued. The patient steadily improved from this date; the bowels were open freely four or five times a day.

On April 22nd there was scarcely any jaundice; no attacks of stupor occurred, and he had good sleep at night; the pulse remained about 100 in rate. The urine was now passed freely, between three and four pints in twenty-four hours, with a specific gravity of 1014, and showing only a very faint trace of albumen on boiling and adding dilute acetic acid. The liver had receded about one and a half inches.

The patient was able to get up and walk about the room. One drachm of sulphate of magnesium was at this time taken thrice daily, and the bowels were in this way kept open four or five times a day.

By May 6th further great improvement had taken place. He could walk upstairs without dyspnœa, and had no pains in the limbs. The urine was plentiful; the pulse 100; no alcohol, and only a vegetable diet, with milk, butter, and cheese, had been taken. The patient continued to abstain from alcohol and meat for eight or ten months.

In the summer of 1900 he did some work—haymaking,—and drank beer and spirits and ate meat again. These articles of diet he gradually took more of, and he became less active and more heavy and torpid mentally.

About August, 1900, he contracted pneumonia, and died on the third or fourth day.

This case of cirrhosis with enlargement of the liver in a stout man shows the utility of promoting very free elimination, especially by the bowels, when symptoms occur of

stupor, twitching, etc., resembling uræmia, and due to combined defective action of the liver and kidneys. The symptoms came on gradually and increased in spite of there being two or three loose actions of the bowels daily, and in spite of meat being removed from the diet and the alcohol being considerably lessened, but very free and continued purgation by the use of the salts of magnesium produced rapid and continued improvement, which lasted for over a year. A partial relapse was due apparently to a return to the former diet.

Notes on the Use of Ethyl Chloride as a General Anæsthetic.

By H. F. PARKER, M.D. (Cantab.).

SOME six months ago there was published in the ST. BART.'S JOURNAL a short account of the use of ethyl chloride as a general anæsthetic, together with a summary of the personal results obtained in some 140 administrations that were carried out at the Wolverhampton and Staffordshire General Hospital.

Not having a copy of the paper at hand at the present time I cannot refer to it in precise terms; but the conclusions that were there drawn as to the utility, convenience, and comparative safety of the drug have been fully maintained by a more extended personal experience, and also by the opportunity afforded of seeing it administered frequently by others.

Altogether at the above-mentioned hospital upwards of 500 administrations have been now performed with but a small percentage of failures, and without the occurrence of any dangerous symptoms except in a single case, which shall be mentioned later.

I may remind readers that, when using a Breuer's mask the ethyl chloride (or kélène) is sprayed on to a piece of gauze contained in a metal globe, through which the air passes before it is breathed by the patient; whilst by means of a double set of valves the expired air is made to escape by a different route.

The main features of the anæsthesia are—

1. Its quick induction, viz. a half to two minutes.

2. The rapid recovery of the patient in from a half to two minutes, even after operations lasting for an hour or more.

3. The pleasant character of the anæsthesia, the absence of embarrassing sequelæ, and the remarkably slight effect that is produced on either respiration or pulse.

4. Its somewhat light character, rendering it an unsuitable anæsthetic for use when abolition of the reflexes and complete immobility are essential.

In cases where nitrous oxide gas would ordinarily be used ethyl chloride is usually as good or even better, and it is readily given as an antecedent to ether. In the latter case the following arrangement is used. Into the top of a Clover's inhaler is inserted a Barth's two-way valve apparatus, and to this again is attached the metal globe of a Breuer's mask. Ethyl chloride alone is at first administered, and then, as consciousness is becoming lost, the ether chamber is gradually rotated until, at the end of some two minutes, it is desirable to replace the valve apparatus by the ether bag.

Ethyl chloride can be used with great advantage for most operations in children (including radical cure of hernia, amputations, etc.), and for most minor and many major operations in adults, more especially in women. It would seem to be the anæsthetic *par excellence* in the operations for "adenoids" and "empyema," since the laryngeal reflex is practically never lost; also in cases of collapse (*e.g.* from serious abdominal disease), where the depressing effect of chloroform itself counts for something against the patient's recovery.

Moreover, although vomiting not infrequently occurs, it is almost always slight, and is never lasting in character.

It should be a most useful and convenient anæsthetic for general practitioners and for dentists. I have not had an opportunity of trying it in midwifery practice, in which it should probably be of considerable service, since the patient can easily hold the mask over her face, and very little anæsthetic is needed to diminish sensibility. At the same time it may be as well to remember that delusions are not uncommonly caused by this anæsthetic, and have, in at least two cases recorded in the literature, led to the making of unfounded charges against the administrator.

In one of the above 500 cases serious cardiac depression occurred, but that under circumstances that might readily have been prevented. The ethyl chloride was being administered by an experienced anæsthetist by the usual method to a somewhat anæmic woman for the extraction of three molar teeth. The patient, to whom the same anæsthetic had been successfully administered on a previous occasion, was seated in an upright position in a chair, and had, as a matter of fact, only a short time before finished her tea. At the end of about two minutes, by which time 5 c.c. had been given, the patient showed signs of syncope, viz. pallor, widely dilated and fixed pupils, and cessation of respiration. Inversion and artificial respiration were at once performed, and she "came round" rapidly in a manner that would probably not have been the case from chloroform, so rapid is the elimination of ethyl chloride from the system. This escape from a fatal accident was a cause for congratulation, and at the same time a lesson that ordinary precautions must not be neglected, and that the upright position is not one that it is well to adopt even for the extraction of teeth.

A Case of Ruptured Femoral Artery and Vein.

By E. H. HUNT, B.M., B.CH.

H. B., æt. 41, carman, was brought up on the evening of July 12th by the police; they could say nothing about him except that he had been found in the street, and it was said that a hay-cart had knocked him down.

He was unconscious, collapsed, pale, cold, sweating, and pulseless; respirations very shallow. A rapid examination revealed no injuries to the head, arms, chest, or abdomen, and patient made slight movements of both legs. He was at once removed to the Surgery Ward, without any diagnosis having been made. He was given Liq. Strych. Hydrochlor. mv hypodermically, and Oiij saline, temp. 107°, was infused into the left basilic vein. After Oij his pulse was comparatively good at the wrist, and he began to talk incoherently and struggle. A more thorough examination again showed no injuries to the arms, head, chest, abdomen, or back. A large hæmatoma was found in the right calf, and the left thigh was greatly swollen from the knee upwards. There were marks of bruising in front of the left thigh, just above the knee, and the circumference of the thigh was two inches more than on the right side. Neither the anterior nor the posterior tibial arteries could be felt pulsating in either foot. The radial pulse was also by now again very feeble. The legs were wrapped in wool and placed with the knees semi-flexed.

The patient remained all night very collapsed, but about 6 a.m. became conscious. It then came out that he had been sitting on the shaft of a hay-cart, when a fire-engine startled the horses. He was thrown into the road, and one or both wheels passed over his legs.

At 10 a.m. on the 13th the circulation in the left foot was obviously very slight, and the veins were distended; there was no sensation below the knee. By the evening all circulation had ceased in the foot, and the veins were empty. A diagnosis of ruptured femoral artery and vein, which had been previously made, was now rendered almost certain.

On the 16th blebs had appeared on the outer side of the left leg below the knee, but patient had recovered some sensation on the inner side of the calf. The temperature had risen to 101°.

On the 17th, after consultation in the ward, Mr. Cripps amputated the left leg through the lower third of the thigh. On dissecting the amputated limb a complete rupture was found through both the femoral artery and vein, just at their entry into the popliteal space. The ends were separated by an inch and surrounded by blood-clot.

The patient made an uninterrupted recovery. The ideal treatment of this case, namely, immediate ligature of the torn vessels, was impracticable, firstly owing to the impossibility of immediate diagnosis, and secondly, owing to the grave general condition of the patient. Also, even in the amputated limb, it was a matter of some difficulty to find the torn ends of the vessels among the blood-clot and bruised tissues. Mere ligature of the femoral artery above the rupture would not have been of much avail; in fact, it is possible that the rupture of the vein was the chief agency in the causation of the gangrene.

I have Mr. Harrison Cripps's kind permission to publish this case.

Notes.

DR. R. HENSLOWE WELLINGTON, of the Middle Temple, has been appointed Deputy Coroner to the City of Westminster and the South-western Division of London.

* * *

DR. CLIVE RIVIERE has been appointed Assistant Physician to the East London Hospital for Children.

* * *

DR. F. A. BAINBRIDGE has been appointed a Research Scholar to the British Medical Association.

* * *

THREE Bart.'s men headed the list in the recent examination for the Indian Medical Service. They were A. T. Pridham, F. P. Mackie, and F. P. Connor, and we offer them our heartiest congratulations.

* * *

WE rejoice that the witty writer of the Smithfield letters is continuing his correspondence. The present epistle furnishes abundant evidence that the author's energy has not been seriously diminished, nor his natural force abated by the distressing affliction to which he alludes in his letter.

* * *

WE have to record the death of H. T. Parker, M.D., an old Bart.'s man, who for some years had been Medical Officer and Inspector of Egyptian Prisons. He was invalided home with enteric fever, and died on the ship at Southampton.

* * *

BY the death on July 30th of Mr. James Thomas Ware, F.R.C.S., in his eighty-sixth year, the Hospital loses one of its oldest members. Mr. Ware, who was the grandson of Mr. James Ware, F.R.S., an oculist of eminence and one of the founders of the Medical Society of London, entered the Hospital in 1835, as the custom then was, as an "articled student" to Mr. Vincent, then surgeon to the Hospital. In process of time he became house surgeon in Colston and Queen (now Lawrence) Wards. In the time of which we are speaking—more than sixty years ago—there were no house physicians and only three house surgeons, and Ware and his colleagues, Bostock and Ormerod, occupied rooms over the Henry VIII gate, while at the Hospital Mr. Ware took an active part in founding the Metropolitan Convalescent Institution, now so well known for its important and beneficial work at Walton, Broadstairs, and Highgate. One of his fellow-students, Theodore Monro, being struck by the necessity of country air for a poor girl in one of the wards, whose leg had been amputated, and who was about to be discharged, though in a state of great weakness, consulted Mr. Ware and a few other fellow-students, and after conferring with their friends they determined to establish a home for convalescents in the country. The result was that they founded what is now known as the Metropolitan Convalescent Institution. At this time there was no such thing as a convalescent home. This institution was the first—the pioneer—of the large number of these useful and

beneficent homes which are now spread all over the country. For many years Mr. Ware took an active part in the management of this charity as a member of the committee, especially as one of its surgeons, and when he was unable to assist in this work he became one of its vice-presidents. When still a young man his health failed for a time, and as a consequence he relinquished the medical profession, though his knowledge of it was of great use to him in after life, especially in reference to his work as chairman of the Board of Guardians of Farnham. On retiring from the profession Mr. Ware settled on his family property at Tilford, near Farnham, where he fulfilled, until laid aside by ill-health in later life, with ever-ready kindness and consideration for others, the various duties that fall to the lot of a country squire.

* * *

THE following were successful at the recent examinations for entrance to the Royal Army Medical Corps:—Mr. A. H. Hayes (sixth); Mr. R. Storrs (tenth); Mr. F. A. H. Clarke (twelfth); Mr. R. L. V. Foster (fourteenth).

* * *

A COMPOSITE picture of famous Bart.'s men and of the Hospital itself has recently been issued to the subscribers by a well-known Cheltenham firm, and has given rise to much dissatisfaction. It was stated that the picture would be printed on India paper; that, however, is not the case. It was further stated that the picture would be signed by Hanhart, whereas it is signed by Hager. Moreover the picture itself contains two very serious errors; the Church of St. Bartholomew the Great is described as St. Bartholomew the Less; and the Roundabout in Smithfield Place is designated the "Square." When one adds that in its general appearance the picture closely resembles a tradesman's Christmas almanack, the annoyance of the subscribers can well be understood.

* * *

IT is rumoured that some of the most distinguished members of the Nursing Staff have lately devoted themselves to bacteriology in the Pathological Laboratory. It has been stated that under their benign influence the anthrax bacillus lost all his virulence, and became as innocuous as a sarcina; that the typhoid bacillus stretched out his flagella, and allowed them to be stained with ease; and that the carbol-fuchsin positively blushed with delight. Such facts speak for themselves, and we need say no more. Doubtless the streptococcus is even now gnashing his teeth with helpless rage, as he reflects on his inability to work his wicked will.

But seriously there can be no doubt that the Nursing Staff is to be congratulated on going to the fountain-head, and gaining a *practical* knowledge both of the organisms of suppuration, and of the most efficient means of destroying them.

Amalgamated Clubs.

RIFLE CLUB.

The competition for the Inter-Hospital Cup took place at Bisley ranges on July 17th. The competition consists of ten shots at 500 yards by teams of six from each hospital, the total aggregate being 300 points.

Bart's and St. Thomas's tied with 226 points each, but according to N.R.A. rules in respect to ties the team with fewest "outers" in the score is considered to have done the best shoot; accordingly, as we had only six outers to St. Thomas's twelve, we were judged the winning team. The Cup therefore comes into our possession for the ensuing year for the first time in its history, and long may it remain.

The somewhat poor score may be accounted for by the variable wind and bad light. Read with 43 was top scorer.

The following represented the Hospital:

A. C. Brown (capt.)	37
W. R. Read	43
J. Morris	35
P. A. Dingle	39
S. H. Andrews	38
W. W. Jeudwine	34
	226

Correspondence.

To the Editor of the St. Bartholomew's Hospital Journal.

DEAR SIR,—Might I draw the attention of medical students to a point which will help them in general practice, especially if that happens to be amongst the educated classes? It is one which I regret not to have paid more attention to when working at the bedside, viz. prognosis.

This is the first question asked by the uneducated and educated alike after, and sometimes before, one's physical examination of the sufferer; diagnosis with the "lower" classes not being so difficult, providing one is sufficiently concise in language and unwilling to revise a diagnosis before them.

The first question asked by anxious relatives is, "What is it, doctor?" Then, "Is it serious?" and "Will he recover?" Other questions of a probing nature rapidly follow, requiring great tact and diplomacy, especially if a man is not quite sure of his ground.

We all know perfectly well that to arrive at a trustworthy prophecy a correct diagnosis must be made, but even if this is made it is often extremely difficult to forecast events, and ward clinicians should make a point of asking themselves the following questions, which will really be of inestimable value in after life:

(1) Is this patient going to die?
(2) How will he die—suddenly or not? painlessly or not?
(3) If he recovers, will it be a complete convalescence?

Another point worthy of remembrance is to be able to warn the relatives of certain complications incident to the particular disease. For a man desirous of "kudos" this is not the least memorable point.

I speak from a few years' short but impressive experience.

I am, sir,

Yours truly,

J. W. MALIM.

Review.

PRACTICAL MEDICAL ELECTRICITY. By DAWSON TURNER, M.D., F.R.C.P.Ed. Third Edition, 7s. 6d. (Baillière, Tindall, and Cox.)

The issue of a third edition of Dr. Dawson Turner's book on Medical Electricity sufficiently indicates the estimation in which it is held. The author within comparatively short limits covers the whole field not merely of static, galvanic, and faradic electricity, but also of the newer applications of electric rays, the Röntgen and Finsen, in the treatment of disease. The book may be regarded as divided into two portions. In so far as it is a practical guide to the equipment and methods to be employed in an electrical department of a hospital it is admirable, concise, lucid, and comprehensive; but when we turn to those pages that deal with therapeutics we must confess to a feeling of disappointment. There is no critical survey of the position at present occupied by this branch of medical treatment, and there appears to us to be a want of balance and restraint in many of the statements made. Perhaps, however, the disappointing character of this section is inherent in the subject; the beneficial uses of electricity as a therapeutic agent are, as the author observes, a matter of empirical and not of scientific knowledge, and the exaggerated claims which have been made in this respect have given rise to much scepticism.

The book is well illustrated and well printed. There is a bad misprint at p. 283; and, if a mere Southron may be permitted to hint at a classical error, "neurites" is not a permissible plural form of "neuritis" (*vide* pp. 213, 215).

Calendar.

Sept. 9.—On duty. Dr. Gee and Mr. Marsh.
" 12.—On duty. Sir Dyce Duckworth and Mr. Butlin.
" 16.—On duty. Dr. Hensley and Mr. Walsham.
" 19.—On duty. Sir Lauder Brunton and Mr. Cripps.
" 22.—Examination for Entrance Science Scholarships and Jeaffreson Exhibition begins.
" 23.—On duty. Sir William Church and Mr. Langton.
" 26.—On duty. Dr. Gee and Mr. Marsh.
" 30.—On duty. Sir Dyce Duckworth and Mr. Butlin.
Oct. 1.—Annual Dinner of Old Students.
Beginning of Winter Session.
" 3.—On duty. Dr. Hensley and Mr. Walsham.

Examinations.

CONJOINT BOARD.

The following have completed the Examinations for the Diplomas of M.R.C.S. and F.R.C.P.:—R. H. Sankey, H. E. Stanger-Leathes, F. W. Cheese, L. Orton, H. W. Atkinson, C. H. Gregory, G. G. Ellett, F. H. Ellis, N. A. W. Conolly, N. Macfadyen, G. S. Ewen, E. L. Martin, G. W. Micklethwait, C. C. Robinson, H. Love, E. G. Pringle, A. A. Meaden, D. H. Evans, E. O. Hughes.

Appointments.

CONOLLY, N. A. W., M.R.C.S., L.R.C.P., appointed Anæsthetist and Junior House Surgeon to the Royal Infirmary, Bristol.

* * *

DOUGLAS, A. R. J., F.R.C.S., appointed Plague Officer by the Indian Government.

* * *

HOOLE, J., M.R.C.S., L.S.A., appointed Medical Officer and Public Vaccinator for the Hartington District of the Ashbourne Union.

* * *

ORTON, G. H., M.B., B.C.(Cantab.), appointed Medical Officer to the Casualty Department at the East London Hospital for Children.

* * *

ROBINSON, C. C., M.R.C.S., L.R.C.P., appointed House Physician at Bethlem Royal Hospital.

* * *

SCRAN, J. J. S., M.R.C S., L.R.C.P., appointed House Surgeon to the Huntingdon County Hospital.

* * *

SMITH, W. C. B., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Hospital, Portsmouth.

* * *

STANGER-LEATHES, H. E., M.R.C.S., L.R.C.P., appointed Casualty Officer to the Royal Infirmary, Bristol.

New Addresses.

GALSWORTHY, L., 6, Brunswick Place, Regent's Park, W.

GRAHAM, C. H., Wellington, New South Wales.

HOOLE, J., Parwick, near Ashbourne, Derbyshire.

PRATT, ELDEN, Henfield, Sussex.

WATSON, C. G., 44, Welbeck Street, W.

Births.

CRACE-CALVERT.—On July 25th, at Vale of Clwyd Sanatorium, Llanbedr Hall, Ruthin, North Wales, the wife of George A. Crace-Calvert, M.B.(Lond.), M.R.C.S., of a daughter.

CRAWFORD.—On June 20th, at the Spring, Pembury, Kent, the wife of Cyril Crawford, of a daughter.

KNIGHT.—August 3rd, at Rotherham, the wife of H. Ernest Knight, M.D.Lond., of a son.

Marriages.

HORDER—DOGGETT.—On September 3rd, at the Parish Church, Newnham, Herts, by the Rev. G. Todd, Vicar, and the Rev. J. T. Inskip, Vicar of Leyton, Essex, Thomas Jeeves Horder, M.D. (Lond.), M.R.C.P., 141, Harley Street, W., youngest son of the late Albert Horder, Wincombe, Swindon, to Geraldine Rose, only daughter of Arthur Doggett, Esq., of Newnham Manor, Baldock, Herts.

WARD—FINCH.—On August 14th, at the Cathedral, Cape Town, by the Rev. Arthur Brooke, Arthur Blackwood Ward, B.A., M.B., B.C.Cantab., M.R.C.S.Eng., L.R.C.P.Lond., of Northumberland Lodge, Bloemfontein, Orange River Colony, to Angela Susan Dorothea, second daughter of the late Henry C. Finch, Esquire, J.P., of Redheath, Watford, in the county of Herts, and of Mrs. Charles Maynard Hallewell, of Vale House, Monkton Combe, Bath.

Death.

WARE.—On July 30th, James Thomas Ware, F.R.C.S., eldest son of the late Martin Ware, Esq., of Tilford, Surrey, and Russell Square, W.C., aged 85.